Adventist HealthCare
Shady Grove Medical Center

Outpatient Wellness Clinic

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

Emergency Contact: _____Relationship: _____Phone:_____

What is the reason for the appointment? _____

_____

_____

Who were you referred by? (Physician, agency/ organization, friend, family member)_____

If physician/agency/organization, please list name: _____

Have you previously received any type of mental health services (therapy, medication management, substance abuse treatment)? □ Yes □No

Briefly describe the treatment you received (i.e. inpatient hospitalization, therapy, residential treatment):

_____

_____

Family history of mental illness/substance use: _____

Primary care physician: _____ Date of last physical:_____

Past medical history: _____

Current medical concerns: _____

Allergies (food, drug, and/or other): _____

Please list ALL medications you are currently taking:

Medication Name	**Dose**	**Frequency**	**Route (oral, injection)**

Marital status: _____

Living situation: _____

Religious/spiritual orientation and cultural preferences: _____

Immigration status: _____

Military history: _____

Education: Current Grade: _____Home schooled? YES NO IEP/504 Plan? YES NO Not applicable

Work status: _____

Adventist HealthCare
Shady Grove Medical Center

Parents/legal guardians of children 17 years of age or younger, please complete:

Is there a legal guardian other than a parent? □ Yes □No

Is there a court-ordered or legal custody arrangement? □ Yes □No

In cases where there is a legal guardian and/or custody arrangement that has been determined by the Court, you must provide Court documentation.

Please initial one of the following:

_____ In case of an emergency my child may be accompanied by and/or released to the following people for his/her office visit(s)*:

Name: _____ Relationship: _____Phone: _____

Name: _____ Relationship: _____Phone: _____

Name: _____ Relationship: _____Phone: _____

OR

_____ My child may ONLY be accompanied by and/or released to me, the parent(s) and/or guardian(s), for his/her office visit(s).

In the event that you would like to grant individuals other than yourself (the parent or legal guardian) the ability to make medical decisions about your child, a notarized document giving these individuals that right will be required in your absence.

Parent or Legal Guardian Signature: _____

Date: _____

Relationship to patient: _____

Patients 15 years of age or young must be accompanied by a parent/legal guardian to all outpatient wellness clinic visits. For patients 16 and 17 years of age, we highly recommend a parent/legal guardian be present for the initial appointment. We acknowledge that this is an inconvenience, but it is necessary to ensure the safety of your child and our staff.

Adventist HealthCare
Shady Grove Medical Center

Outpatient Wellness Clinic

Appointment Policy

Thank you for choosing the Outpatient Wellness Clinic. It is important that our patients have a clear understanding of our Appointment Policy. Please read the following, and sign the enclosed document stating you have read this information. If you have any questions or concerns, please let the front desk team know.

Appointment Policy:

Patients who need to reschedule or cancel their appointment are expected to call the front desk more than **24 hours** before their appointment. Patients who do not show for their appointments, or who call the same day to cancel/reschedule, are considered a "No Show". After three (3) "No Shows", the patient will be discharged from services.

Patients who are late to their appointment may not be seen. Patients who are late on multiple occasions will be discharged from services.

Adventist HealthCare
Shady Grove Medical Center

Outpatient Wellness Clinic

Appointment Policy

Patient Name: _____ Date of Birth: _____

I have read the Outpatient Wellness Clinic Appointment Policy.

Patient or Legal Guardian Signature: _____

Date: _____

Relationship to patient: _____

We are a *hospital-based* outpatient clinic.

Patients seen in a clinic or outpatient setting **will** receive separate bills for hospital and physician services. ***Hospital bills (also known as "facility bills") will come in the mail after the date of service.***

We highly encourage you to check with your insurance to verify your coverage. We have found that many insurance providers apply different deductibles and co-insurance amounts to hospital-based clinics than they do to physician offices.

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.

Adventist HealthCare
Shady Grove Medical Center

Patient Name: _____ Date of Birth: _____

Statement of Financial Responsibility

Thank you for choosing the Outpatient Wellness Clinic. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.

- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- The Outpatient Wellness Clinic is a department of Shady Grove Medical Center. Patients seen in a clinic or outpatient setting **will** receive separate bills for hospital and physician services.
- The clinic or outpatient charges will be billed by Shady Grove Medical Center and will include charges for the use of the facility and any tests or procedures done at the time of your appointment.
- Physician services will be billed separately by Adventist Medical Group.
- Patients are responsible for payment of copays, coinsurance, deductibles **for both the physician bill and the facility bill** as well as all other procedures or treatment not covered by their insurance plan. **Please be sure you are aware of our physician and outpatient facility copays, coinsurance and deductibles**.
- Copays are due at the time of service.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable.

By my signature below, I understand that I am financially responsible for any and all charges not covered by my health insurer for services provided by the Outpatient Wellness Clinic.

_____ _____
Signature Date

_____
Print Name

Adventist HealthCare
Shady Grove Medical Center

PATIENT CONSENT

Patient Name:_____ Date of Birth_____

CONSENT FOR TREATMENT

The undersigned authorizes Adventist HealthCare Shady Grove Medical Center, its staff and physicians to render to the patient all customary care, therapy, treatment, tests and procedures considered advisable, including emergency treatment, dental and transportation to another facility if necessary.

PRESCRIPTION HISTORY CONSENT

The undersigned authorizes Adventist HealthCare Shady Grove Medical Center to retrieve prescription history multiple or other unaffiliated medical providers, insurance companies and benefit managers and may be viewed by the providers and staff in the Outpatient Wellness Clinic, and may include prescriptions issued in past years.

CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

It is our policy to take every measure to protect the privacy of your health information. However, your protected health information may be used and disclosed in order for us to carry out treatment, payment or health care operations. For our policies regarding the protection of your health care information, please refer to our **Notice of Privacy Practice**. It is your right to review our policies prior to signing this consent. The terms in the **Notice of Privacy Practice** may, at times, be revised and a current Notice will always be available in our office.

As stated in our **Notice of Privacy Practice**, you have the right to restrict how we use your protected health information in order to carry out treatment, payment or health care operations, although we are not required to agree to these restrictions. If we do agree to these restrictions, the restriction will be binding on the provider.

You have the right to revoke this consent in writing, except to the extent that we may have already taken action in reliance on it.

Signature of Patient/Patient's Representative _____Date_____Relationship to Patient _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Notice of Privacy Practice and consent to the disclosure of my health information for the purpose of treatment, payment and health care operations.

Signature of Patient/Patient's Representative _____Date_____Relationship to Patient _____

PAYMENT POLICY

I certify that the information I have reported regarding my insurance coverage is correct and that any services not covered under my insurance plan will be my responsibility. I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for the patient named above.

Signature of Patient/Patient's Representative _____Date_____Relationship to Patient _____

ASSIGNMENT OF BENEFITS

I authorize Adventist HealthCare Shady Grove Medical Center to apply for benefits on my behalf for the covered services rendered. I request that payment be made directly to the above-named provider, or in the case of Medicare Part B benefits and Medigap benefits, to myself or the party who accepts assignment. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked, by either me or the above-named carrier, at any time in writing.

Signature of Patient/Patient's Representative _____Date_____Relationship to Patient _____

RECEIPT OF PATIENT RIGHTS & RESPONSIBILITIES

I acknowledge receipt of Adventist HealthCare's Patient Rights & Responsibilities

Signature of Patient/Patient's Representative _____Date_____Relationship to Patient _____

Adventist HealthCare
Shady Grove Medical Center

Authorization for Release of Information

Outpatient Wellness Clinic
14915 Broschart Road, Suite 2200, Rockville, MD 20850
Phone: 301-838-4912
Fax: 301-251-4666 eFax: 1-888-766-7701
OWC@AdventistHealthCare.com

Date: _____

Patient Name: _____ DOB:_____
I hereby authorize the Adventist HealthCare Shady Grove Medical Center Outpatient Wellness Clinic to (check all that apply):

□ Release
□ Obtain

The following information pertaining to behavioral or mental health services, drug and or alcohol diagnosis and treatment to/from:

Name/Organization: _____ Phone:_____
Address: _____ Fax :_____

The information to be released/obtained is as follows –
(**INITIAL** next to all that apply):

_____Medication List
_____Treatment plan
_____Discharge/transfer summary
_____Psychiatric evaluation (by psychiatric provider)
_____Psychiatric provider progress notes
_____Therapist evaluation
_____Therapist progress notes
_____Verbal Communication
_____Laboratory reports (if OWC is obtaining records)
_____History and Physical (if OWC is obtaining records)
_____Other: _____

Purpose of Disclosure: □ Coordination of care
□ Participation in treatment
□ Other: _____

1. I understand that this authorization is voluntary.
2. I understand that the patient's health care and payment will not be affected if I do not sign this form.
3. I understand that I may revoke this authorization in writing at any time except to the extent that Adventist HealthCare Shady Grove Medical Center, or its employees or agents have acted upon this authorization. My written revocation must be submitted to the Outpatient Wellness Clinic.
4. I understand that if the organization authorized to receive this information is not a health plan or health care provider and if such information is re-disclosed by the recipient, the released information may no longer be protected by federal privacy regulations but may be protected under Maryland law.
5. I understand that I may receive a copy of this form after I sign it and that I may inspect and request a
6. copy of the information that I am authorizing for use/disclosure.

This authorization will expire one year from today's date, unless otherwise specified here: _____

Signature of Patient/Patient's Representative: _____ Relationship to Patient:_____

Print Name: _____ Date: _____

Adventist HealthCare
Shady Grove Medical Center

Patient Rights and Responsibilities

MISSION: We extend God's care through the ministry of physical, mental and spiritual healing.

You, the patient, and/or when appropriate, patient's representative, have the following rights and responsibilities:

YOU HAVE THE RIGHT:

1. To receive a copy of patient rights upon admission.
2. To have a family member or representative of his/her choice and his/her own physician notified promptly of his/her admission to the hospital.
3. To appoint a surrogate decision-maker in the event the patient is unable to make decisions about care, treatment or services, or choose to delegate decision making to another.
4. To designate a family member or support person of the patient's choice to serve as a source of emotional support.
5. To designate an adult Lay Caregiver by a patient, or the Legal Guardian of a patient, who performs aftercare for the patient at the residence of the patient.
6. To have the patient's personal culture, values, beliefs and preferences respected.
7. To expect the patient's personal privacy to be respected to the fullest extent consistent with the care prescribed and applicable law.
8. To be involved in the decision making with the patient's physician, talking in language he/she may reasonably be expected to understand, about diagnosis, treatment prescribed, prognosis and any instructions required for follow-up care. Persons not directly involved in the patient's care must have the patient's permission to be present.
9. To create Advance Directives (Living Will/Durable Power of Attorney) and appoint a surrogate to make health care decisions on the patient's behalf to the extent permitted by law.
10. To have access to interpretative services, when necessary and appropriate, to prevent language barriers from hampering the patient's care; for the hearing or visually impaired, to have access to appropriate audiovisual aids.
11. To have requests courteously received and properly considered as quickly as circumstances permit.
12. To know the name of the physician, nurses, and team members responsible for the patient's care.
13. To be informed of the reason for various tests/treatments and the roles of team members providing the care.
14. To be involved in the informed consent process that includes a discussion about potential benefits, risks, and/or side effects of a proposed treatment/ care/services, the likelihood of achieving the goal and/or potential problems that might occur during recuperation.
15. To change his/her mind about any procedure for which the patient has given consent or to refuse treatment and to be informed of the medical consequences of this action.
16. To be informed about the outcomes of care, including unanticipated outcomes.
17. To complete information as to the reason for a transfer to another institution if necessary (including the alternatives to such a transfer) and the knowledge that the other institution has accepted him/her for transfer.
18. To access pastoral care or other spiritual services.
19. To request through the attending physician a second opinion by another physician; to change physicians; or to change facilities.
20. To participate in ethical discussions that arises in the course of care delivery including issues of conflict resolution, withholding resuscitative services, foregoing or withdrawal of life sustaining treatment and participation in investigational studies or clinical trials.
21. To receive care and treatment in a safe environment.
22. To have pain managed in a compassionate manner.
23. To access protective services to include guardianship, advocacy services, state/local licensure agencies, and protective interventions.
24. To have impartial access to the medical resources of the hospital indicated for his/her care without regard to race, color, creed, national origin, age, sex, handicap, or source of payment.
25. To refuse to participate in medical training programs and research projects.
26. On request, made within 30 days of either discharge or payment, to receive a bill that is itemized and describes briefly but clearly each item and the amount charged.
27. To expect all communications and records pertaining to his/her care, including the source of payment for treatment, to be kept confidential, to the extent required by law.

BEHAVIORAL HEALTH SETTINGS:

28. To receive medical treatment for medical emergencies.
29. To review the medical record with the patient's physician within a reasonable time to see part of or all of the medical record unless his/her physician documents that it is medically contraindicated (such reasons are to be documented in the medical records).
30. To reasonable access to a telephone unless a restriction is made for any reason (such reasons are to be documented in the medical record).
31. To not be deprived of the right to vote or to receive, hold, and dispose of property solely because he/she is a patient.
32. To public benefits for which he/she may be eligible.
33. To be informed of use and the purpose of audiovisual tapes and equipment prior to their use.
34. To an environment that preserves dignity and contributes to a positive self-image.
35. That if the patient is disoriented or lacks the capacity to understand his/her rights at the time of entry, he/she is informed again when he/she is able to understand.

PATIENT RESPONSIBILITIES:

1. To provide, to the best of his/her knowledge, accurate and complete information about present complaints, medications, past illnesses, hospitalizations and other matters relating to his/her health care.
2. To provide information about Advance Directives; giving directions about his/her future medical health care should he/she become incapable of participating in such discussions.
3. To ask questions about his/her treatment, diagnosis or prognosis and tell his/her physician about a change in his/her condition or problems that arise.
4. To be considerate of the rights of other patients and medical personnel, to assist in the control of noise, and to follow the AHC non-smoking, visitor, and other rules.
5. To be cooperative and considerate during the treatment and care prescribed.
6. To respect the privacy of other patients.
7. To accept his/her financial obligations associated with his/her care.
8. To advise his/her nurse/physician and/or Patient Representative of any dissatisfaction he/she may have in regard to his/her care at the hospital.

Adventist HealthCare

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PATIENT RIGHTS AND RESPONSIBILITIES

9510-129 (05/17)

Patient Identification

Adventist HealthCare
Shady Grove Medical Center

Outpatient Wellness Clinic
Hours of Operation, After-Hours Protocol & Support Hotlines

Hours of Operation

Monday-Thursday 8:00 a.m. – 6:00 p.m.
Friday 8:00 a.m. – 3:00 p.m.
14915 Broschart Road, Suite 2200
Rockville, MD 20850
301-838-4912

After-Hours Protocol

The Outpatient Wellness Clinic does not provide after-hours coverage.
This means that if you are experiencing a crisis or a medication issue that cannot wait until the next business day, *you should call 911 or go to the nearest hospital emergency room*.

Support Hotlines

Montgomery County Crisis Center
240-777-4000

Suicide Prevention Hotline
1-800-SUICIDE (784-2433)

Domestic Violence Hotline
1-800-799-7233

Domestic Violence Hotline (Hearing Impaired)
1-800-787-3224

Child/Elder Abuse Hotline
1-800-222-8000

Addiction Helpline
1-800-559-9503

Adventist HealthCare
Shady Grove Medical Center

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

Treat you: We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Govern our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

A Health Information Exchange, or HIE, is a way of sharing your health information among participating doctors' offices, hospitals, care coordinators, labs, radiology centers, and other health care providers through secure, electronic means. The purpose is so that each of your participating healthcare providers can have the benefit of the most recent information available from your other participating providers when taking care of you. Information flowing through the HIE can also be made available to researchers with appropriate consent through a careful review and approval process. When you opt- out of participation in the HIE, doctors and nurses will not be able to search for your health information through the HIE to use while treating you and your information will not be available for research. Your physician or other treating providers will still be able to select the HIE as a way to receive your lab results, radiology reports, and other data sent directly to them that they may have previously received by fax, mail, or other electronic communications. Additionally, in accordance with the law, Public health reporting, such as the reporting of infectious diseases to public health officials, will still occur through the HIE after you decide to opt out. Controlled Dangerous Substances (CDS) information, as part of the Maryland Prescription Drug Monitoring Program, will continue to be available through the HIE to licensed providers.

Adventist Healthcare participates in three levels of health information exchange:

- Adventist Health Information Exchange – Local
- Chesapeake Regional Information System for our Patients (CRISP) * – State
- Commonwell - National

* We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers. You have rights to limit how your medical information is shared. We encourage you to read Notice of Privacy Practices for CRISP and find more information about CRISP medical record sharing policies at www.crisphealth.org.

You may decide to opt-out of sharing your data with the health information exchanges. Please speak with a representative at the front desk or registration for instructions on the opt-out processes.

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- **We are required by law to ensure that authorization from an individual for a use or disclosure of protected health information is voluntarily provided expect in certain circumstances including the research context. As a result, we will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits to the provision of an authorization to disclose protected health information.**
- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

No persons shall, on the grounds of race, color, religion, age, sex, national origin, ancestry, sexual orientation, gender identity, or disability, be excluded from participation in, be denied services, or otherwise be subjected to discrimination in the provision of any care or treatment.